MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51JA	A. BUILDING: _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
J G ALEXANDER NURSING CENTER	25112 HIGHWAY 15 UNION, MS 39365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and Complaint Investigation (CI), MS #26987, at the facility from 01/27/25 through 01/30/25. The SA investigated CI MS #26987 for resident abuse, quality of treatment, and restraints related to a fracture of unknown origin. There were no citations related to the complaint investigation. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500, M645 and M815.	M 000		
M 645	45.21.9 Nutrition Nutrition. Residents shall maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless residents ' clinical condition indicates that this is unavoidable. All residents shall receive diets as orders by their physician or nurse practitioner/physician assistant. Residents identified with significant nutritional problems shall receive appropriate medical nutrition therapy based on current professional standards. This Statute is not met as evidenced by: Level III Based on observation, interviews, and record review, the facility failed to ensure that a resident did not experience a significant weight loss of over 10% in six months, as evidenced by Resident #45 was observed to be lethargic and was unable to intake appropriate nutrition to sustain weight. Resident #45 did not have Registered Dietitian (RD) interventions implemented when ordered and did not have medications reviewed for one (1) of sixteen (16) sampled residents (Resident #45)	M 645	1) On 1/29/2025, Director of Nurses(DON) notified physician of the weight loss, lethargy, Dietician□s interventions, and medication review for Resident #45, Consultant Pharmacist completed consult for medication review, and Director of Nurses (DON) received new physician□s orders, and updated resident care plan accordingly. (See Exhibit 692A) 2) All residents have potential to be	2/22/25

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M 645	Continued From page 1 Cross Reference F580 and F758 Findings included: During an observation and interview on 01/27/2025 at 1:01 PM, with Resident #45's family member, the resident was in his room for lunch. He was drowsy and did not wake up for the CNA who was attempting to feed him. He eventually woke up to eat two (2) small bites of food when encouraged by the family member. The family member expressed concern that the resident had lost approximately 20 pounds since being discharged from a behavioral health hospital in March 2024. During an observation on 01/28/2025 at 12:10 PM, Resident #45 was in the dining hall but remained asleep throughout the entire lunch period and did not wake up despite multiple attempts by CNA #1. During an interview on 01/29/2025 at 11:23 AM, Registered Nurse (RN)#2 stated that psychiatric services were being ordered for Resident #45 because his son requested a psychiatric consultation on 01/24/2025. RN #2 confirmed that the resident had not received a psychiatric follow-up since returning from the behavioral health hospital ten (10) months ago. During an observation on 01/29/2025 at 1:59 PM, Resident #45 was asleep in his wheelchair in the common area near the nurses' station. During an interview on 01/29/2025 at 3:12 PM, the Director of Nursing (DON) confirmed that a psychiatric consultation for medication management had not been in progress until the	M 645	affected by the same deficient practice. 3) a. On 1/31/25, Quality Assurance (QA) revised Policy and Procedure related-to identification of chronic care issues related-to weight loss, lethargy, and proper implementation of Dietician□s recommendations and Consultant Pharmacist□s medication reviews in order to ensure that chronic illness and dietary recommendations for residents with chronic illness are properly treated. (See Exhibit 692B) b. On 2/3/25, facility Administrator completed contracting update with facility contract Nurse Practitioner in order to implement facility-wide Nurse Practitioner continuing monitoring of chronic care including, but not limited to, implementation of Dietician□s recommendations and proper identification of and treatment for weight loss, lethargy, and Consultant Pharmacist□s and Psychological Services Provider□s medication review consultations. (See Exhibit 692C) c. On 1/31/25, facility Administrator completed new contract with facility psychiatric care provider in order to implement facility-wide psychological continuing monitoring of care including, but not limited to, proper implementation of medication reviews. (See Exhibit 692D) d. On 2/14/2025, facility contract Nurse Practitioner initiated quarterly in-service training for all licensed nursing staff related-to proper implementation of Dietician□s recommendations and chronic care monitoring including, but not limited	

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M 645	Continued From page 2 resident's son requested the consultation on 01/24/2025. The DON stated that it was standard practice for the facility's Medical Doctor of Behavioral Health (MDB) to follow up with residents discharged from behavioral health units but acknowledged that this did not occur in this case. During an observation on 01/30/2025 at 9:35 AM, Resident #45 was asleep in his wheelchair in his room. On 01/30/2025 at 11:45 AM, during an interview the Medical Director stated he was unaware of the resident's weight loss and had not been notified by nursing staff. He stated that the resident was prescribed multiple psychotropic medications, including Rexulti, which could cause lethargy, and Trileptal, which could affect appetite. He explained that he should have been informed of the weight loss through dietitian reports in Quality Assurance meetings but had not been made aware. He acknowledged that the weight loss should have been addressed sooner. During an interview on 01/30/2025 at 1:41 PM, RN #3 stated that Resident #45 had exhibited altered sleep patterns prior to his psychiatric hospitalization but that his drowsiness had worsened in the past few months, causing him to miss meals. A record review of the "Progress Notes" revealed Resident #45 had a "Nutrition/Dietary Note", 9/11/2024, authored by the Registered Dietitian (RD), that indicated, " ...WT (Weight) Change: -3.7% x (times) 1 mo (month), -6.6% WL (Weight Loss) x 3 mo, -18.8% SWL (Significant Weight Loss) x 6 mo ...Comments ...Intake does not meet nutritional needs. Resident has	M 645	to, identification of weight loss, lethargy, and residents in need of medication reviews. (See Exhibit 692E) 4) a. On 2/4/25, the Director of Nurses (DON) implemented monthly Chronic Care Audit in order to ensure proper implementation of Dietician□s recommendations and proper identification of lethargy, weight loss, and residents in need of medication reviews. (Exhibit 692E) b. Beginning no later than 2/21/2025 Quality Assurance (QA) will meet and receive the data related to all pertinent audit(s) and in-services on a monthly basis for at least three months, and determine pertinent corrective measures as well as the continued frequency of relevant audit(s) and in-services based upon findings and results achieved.	

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experienced a continued WL with a SWL for 6 mo. Resident observed asleep in bed this morning. Resident has been receiving a SF (Sugar Free) house supplement TID (three times daily) but this was DC'd (Discontinued) on 9/10/25. Oral intake of meals has declined over the last month ...Interventions: 1. House Supplement 8 oz (ounces) TID at medpass - document intake on eMAR (electronic Medication Administration Record) ..."

A record review of the "Progress Notes" revealed Resident #45 had a "Nutrition/Dietary Note", 11/13/2024, authored by the Registered Dietitian (RD), that indicated, " ...Resident has experienced SWL x 6 mo. RD recommended a house supplement 8 oz BID at medpass at last visit in October. It does not appear the supplement was implemented ...WT Change ...-13% SWL x 6 mo ...Comments ...Intake does not meet nutritional needs ...RD recommended a supplement at the last 2 visits. Recommendation was not implemented ...Interventions: 1. House Supplement 8 oz BID at medpass - document intake on eMAR ..."

A record review of Resident #45's weight summary revealed that the resident weighed 191 pounds on 03/04/2024 and 158 pounds on 01/17/2025, reflecting a total weight loss of 33 pounds in ten (10) months.

A record review of Resident #45's meal intake percentages from 01/01/2025 through 01/28/2025 revealed his documented meal intake was between 0-25 percent of meals on thirteen (13) of twenty-eight (28) days.

A record review of the eMAR for Resident #45 for October 2024, November 2024, December 2024,

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and January 2025 revealed there was no documentation that MedPass was administered as recommended by the RD.

A record review of Resident #45's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/27/2024 revealed in Section N that the resident received antipsychotics on a routine basis. Section K revealed the resident had lost five (5) % percent or more of his weight in the last month or ten (10) % in the last six months. Section I indicated that the resident had current diagnoses of Alzheimer's Disease and Dementia. Section C revealed a Brief Interview for Mental Status (BIMS) score of (5), which indicated the resident's cognition was severely impaired.

A record review of the "Order Summary Report" with active orders as of 1/29/25 revealed Resident #45 had a physician's order dated 3/4/24 for a Low concentrated sweets diet with regular texture related to Type 2 Diabetes Mellitus with hyperglycemia, an order dated 4/2/24 for Trileptal 150 milligrams (mg) to be given twice daily for Dementia with Agitation and Depression and an order dated 4/2/24 for Rexulti 1 mg to be given daily for Dementia with Agitation. There were no current orders for the House Supplement of MedPass as recommended by the RD.

A record review of Resident #45's "Admission Record" revealed the facility admitted the resident on 03/04/2024 with a diagnosis of Alzheimer's Disease, with an onset date of 04/04/2024.